"We Treat Your Pets Like Our Own"

FISHERS VETERINARY HOSPITAL
11955 ALLISONVILLE RD.
FISHERS, IN 46038
(317) 842-5865

CARMEL VETERINARY CLINIC
12530 N. GRAY RD.
CARMEL, IN 46033
(317) 846-5707

BROOKSCHOOL ROAD VETERINARY CLINIC
11681 BROOKSCHOOL RD. #4
FISHERS, IN 46037
(317) 585-4730

4-YEAR ACCREDITATION
AAHA
AMERICAN ANIMAL HOSPITAL ASSOCIATION
Excellence in Small Animal Care

fishersvetassoc@sbcglobal.net

Fishers Veterinary Associates
Authorization for Release of Medical Records

Client's Name: _____
Address: _____
City, State, Zip: _____
Phone: _____

In accordance with Indiana State Law, pet medical records may not be disclosed without the client's written consent to "any person other than the client or other veterinarians involved in the care or treatment of the animal". By signing this agreement, I authorize Fishers Veterinary Associates to provide a copy, summary, or narrative of my pet's medical records or to otherwise release confidential information as indicated below.

Pet's Name: _____
Breed/Color: _____
Age: _____

_____ Current Vaccination Certificate sent via fax or mail

_____ Complete patient history of care

_____ Discuss with Boarding Kennels/Grooming Salons verbally about current vaccination information

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This document serves as my authorization for a veterinarian *(or his/her designee)* at Fishers Veterinary Associates to release the medical history of any of my pets as deemed necessary at the time of the request including medications and/or treatments past and present. This document shall be placed in my file and is in effect immediately upon receipt by that facility and/or the date below, and shall remain in effect until written instructions direct otherwise.

Client Signature _____ Date_____